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Development and Implementation of a Healthcare Volunteer Retention Program

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This Manuscript Partially Fulfills the Requirements for the

Doctor of Nursing Practice Program and is Approved by:

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December 1, 2020

**University of St. Augustine for Health Sciences
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DNP Project Primary Faculty: <small>Sarah M. I. Cartwright, DNP, MSN-PH, BAM, RN-BC, CAPA, FASPN</small>		11/30/2020
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Abstract

Practice Problem: Healthcare volunteer responders are an asset during disasters, and their retention is necessary to meet rising demands. This project aimed to develop and implement an evidence-based practice change using a healthcare volunteer retention program and evaluate its influence on retention.

PICOT: The PICOT question that guided this evidence-based practice project was: In healthcare volunteers, how does the participation in a formal healthcare volunteer retention program influence healthcare volunteer retention rate, intent to stay, and volunteer satisfaction 12 weeks after Healthcare Volunteer Retention Program introduction?

Evidence: The evidence from the literature supported mentoring, education and training, and social support to retain healthcare volunteers.

Intervention: The Iowa Model Collaborative guided this project using the Plan, Do, Study, and Act framework to implement the Healthcare Volunteer Retention Program. Healthcare volunteer retention, education and training, and surveys before and after implementation were monitored to evaluate the retention program's influence.

Outcomes: The implementation resulted in a retention rate of 98%, the intent to stay improved by 6%, and 89% of the survey participants were satisfied with the retention program.

Additionally, a paired-samples *t*-test conducted to compare the survey's results before and after implementation resulted in a *t*-value of 3.508 at $\alpha = .05$, which supported the effectiveness of the retention program.

Conclusion: Local, regional, national, and worldwide opportunities exist to build capacity for healthcare volunteers. Disaster response readiness by healthcare volunteers requires mentoring, education and training, and social support to improve this workforce's retention.

Development and Implementation of a Healthcare Volunteer Retention Program

Disasters such as extreme weather, major transportation accidents, and fire-related destruction have affected individuals worldwide (Keim et al., 2019). Disaster health responders offer relief and comfort to those who suffer from natural disasters and public health emergencies. According to Smith and Grove (2017), in two years, the American Red Cross (ARC) deployed 50,000 volunteers across the country to support victims of 125,000 domestic disasters. The provision of health and safety during disasters by healthcare volunteers (HVs) is in high demand, and volunteer retention strategies are crucial. Globally, numerous studies have documented the rising need for retention of HVs (Albuquerque et al., 2018; Chatio & Akweongo, 2017; Haski et al., 2018; Mlotshwa et al., 2015; Moghaddam et al., 2018; Ngugi et al., 2018; Omoto & Packard, 2016; Salmani et al., 2019; Sarti et al., 2017).

The purpose of this project was to develop and implement an evidence-based practice (EBP) change using a Healthcare Volunteer Retention Program (HVRP) to:

- influence retention of HVs,
- influence the HVs' intent to stay, and
- improve the satisfaction of the HVRP.

This paper includes discussions of the significance of this practice problem, the population, intervention, comparison, outcome, and timing (PICOT) of the PICOT question, the evidence-based practice framework and change theory, the evidence search strategy, search results and evaluation, a synthesis of the literature, and themes from the evidence. Furthermore, the paper outlines practice recommendations, project setting and overview, the project plan and method, results, impact, plans for dissemination, and a conclusion to this evidence-based practice change project.

Significance of the Practice Problem

Disasters affect the overall health and well-being of many individuals. Humanitarian organizations rely on HVs to address public health needs during the direst of situations. However, we face a shortage of HVs across the world. The global healthcare worker shortage was 4.3 million in 2006, increased to 7.2 million in 2013, and is expected to rise to 12.9 million by 2035 (Afari-Asiedu et al., 2018). Therefore, innovative approaches to retain HVs are indispensable (Afari-Asiedu et al., 2018). Nonprofit organizations face competition for healthcare workers and retention of humanitarian volunteers (Smith & Grove, 2017).

Humanitarian Needs

In 2018, a total of 850 natural catastrophic losses occurred around the world, which resulted in 15,000 fatalities and a monetary loss of \$186,000 million (Insurance Information Institute, 2020). As of March 2019, 355 fatalities resulted from 108 natural disaster events in the United States, with an estimated monetary loss of \$81.9 million (Insurance Information Institute, 2020).

Regionally, communities in Texas have suffered a variety of tropical storms, hurricanes, and flooding. In August 2017, Hurricane Harvey, a Category 4 storm, dropped 50 inches of rain, flooding more than 150,000 homes in one county, and causing at least 36 deaths (Trevizo, 2020). This storm required over \$125 billion in recovery costs (Trevizo, 2020). In September 2019, Tropical Storm Imelda caused flooding in at least 17,000 homes by dumping over 40 inches of rain and led to five people's deaths (Trevizo, 2020).

HVs are an essential resource for public health response (Smith & Grove, 2017). Locally, the Rio Grande Valley in Texas has suffered substantial flooding, causing many people to seek shelter in the area (Gutierrez, 2019). A lack of HVs was evident during those floods, as

individuals with multiple co-morbidities lost medications, durable medical equipment, and other basic supplies (Abbott, 2019).

Volunteer Retention

Low retention of humanitarian workers threatens the effectiveness of responses to disasters (Albuquerque et al., 2018). Albuquerque et al. (2018) described the need to strengthen retention strategies to improve humanitarian aid. In Africa, several studies have explored factors affecting retention of community-based health volunteers (CBHV), community health workers (CHW), and the sustainability of health activities (Afari-Asiedu et al., 2018; Chatio & Akweongo, 2017; Mays et al., 2017; Mlotshwa et al., 2015; Ngugi et al., 2018; Vareilles et al., 2015). These researchers have suggested mentoring, education and training, and social support to encourage volunteer retention (Afari-Asiedu et al., 2018; Chatio & Akweongo, 2017; Mays et al., 2017; Mlotshwa et al., 2015; Ngugi et al., 2018; Vareilles et al., 2015).

Beliefs, motivations, barriers, and psychological contracts in volunteerism have been investigated in the United States and Canada. These authors have recommended specific volunteer retention strategies to address the effectiveness and sustainability of world health needs in an unstable social and conflict-prone environment (Haski et al., 2018; Kim et al., 2019; McGeehan et al., 2017; Omoto & Packard, 2016; Sarti et al., 2017; Smith & Grove, 2017; Wilson & Son, 2018).

Failure to address this humanitarian need for retention of HVs may have dismal consequences for victims of disasters (Salami et al., 2019; Smith & Grove, 2017; Wilson & Son, 2018). The retention of HVs poses a challenge for many volunteer organizations that compete with local healthcare systems and are already overwhelmed due to insufficient staffing during disasters and public health emergencies.

PICOT Question

The PICOT question for this EBP project is: In healthcare volunteers, how does the participation in a formal healthcare volunteer retention program influence healthcare volunteer retention rate, intent to stay, and volunteer satisfaction 12 weeks after healthcare volunteer retention program introduction? Adults, 18 years of age and older with a healthcare skill, state license or certification, enrolled in the Disaster Health Service (DHS) activity from an interdisciplinary volunteer organization (IVO) served as the population for this EBP project (ARC, 2019a). The project manager (PM) was the Doctor of Nursing Practice (DNP) student who implemented this EBP change project.

The intervention was to develop, implement, and evaluate the HVRP to influence healthcare volunteer retention rate, intent to stay, and volunteer satisfaction at the IVO. According to Salmani et al. (2019), operational requirements are necessary for managing HVs. The HVRP is a guide used by a mentor and HVs with 30-, 60-, and 90-day reviews (see Appendix A) to navigate the onboarding and retention of HVs for mentoring, education and training, and social support to foster self-confidence and collaboration (Salmani et al., 2019). This HVRP utilizes the organization's existing volunteer handbook, standards and procedures, job training tools, and other resources (ARC, 2017; ARC, 2019b). The comparison question was whether differences and reasons exist for those who dropped out of the HVRP.

Permission was granted (see Appendix B) to use the Volunteer Functions Inventory (VFI) data collection tool (see Appendix C), which has been identified as the best-known survey for volunteer motivation, intent to stay, and volunteer satisfaction (Clary et al., 1998). The VFI was used to collect and compare data before and after implementing the HVRP (Alfes et al., 2017;

Clary et al., 1998). Those who dropped out of the HVRP were analyzed separately. Data collection occurred throughout the EBP project to determine outcomes.

EBP Framework and Change Theory

Evidence-based practice is integrating “scientific knowledge with clinical expertise” to solve clinical issues and achieve the best outcomes in the delivery of patient care (Agency for Healthcare Research & Quality [AHRQ], n.d.-b, para. 1). The EBP-driven Iowa Model Collaborative (IMC) guided this project to improve system changes and promote sustainability (IMC, 2017). The IMC has been successfully employed in multiple settings by novice to expert users to change health system outcomes positively (IMC, 2017). The Plan-Do-Study-Act (PDSA) framework is well-known, easy to follow, and reliable (AHRQ, 2018). The PDSA has proven effective in healthcare to test whether proposed changes lead to improvement and evaluate the improvement, costs, and other impacts (AHRQ, 2018).

A change model is most effective at guiding behavior and improving its implementation’s success when paired with careful monitoring using validated tools to sustain change (Institute for Healthcare Improvement, 2020). The PM applied Kurt Lewin’s (1947) three-stage model of change: *unfreezing*, *moving*, and *refreezing* in this EBP project with the HVRP at the IVO for behavior change.

During the unfreezing phase (Lewin, 1947), HVs resisted the change of the HVRP for the management of HVs. However, as Lewin (1947) predicted, belief in the need for the change eased passage into the next stage. The PM shared baseline data to retain healthcare volunteers, which improved transparency, commitment, and collaboration. Next, during the moving stage (Lewin, 1947), the leadership, staff, and HVs became familiar with and accepted the HVRP. Finally, during the refreezing phase (Lewin, 1947), the HVs and staff focused on the mission and

embraced the HVRP. The implementation of the HVRP took place and became the new normal (Lewin, 1947). The mentors and HVs were aware of the expectations and sustained the process. The PM reported the final data to staff, HVs, and mentors. Lewin's Change Theory (1947) was the best fit for a healthcare innovation during a crisis and set the stage for positive change at the IVO.

Evidence Search Strategy

The PM conducted a literature review to find the evidence supporting this question: In HVs, how does the participation in a formal HVRP influence healthcare volunteer retention rate, intent to stay, and volunteer satisfaction 12 weeks after HVRP introduction?

The PM completed an electronic initial database search using the advanced search of the Cumulative Index to Nursing and Allied Health Literature Complete (CINAHL), PubMed, and MEDLINE. Employing Boolean Operators such as *AND* and *OR*, focused the search results. The headings and keywords for all searches were: *volunteering OR volunteer OR volunteerism, AND healthcare professionals OR healthcare volunteers OR healthcare providers OR physician OR nurse OR doctor, AND retention*. The search mode was *find all my search words*, and expanders included *apply related words* and *apply equivalent subjects*. The general limiters were *English language only* and *publication date frame of 2015 to 2020*. The results were: CINAHL 22 citations, PubMed 64 citations, and MEDLINE 24 citations. The PM found and combined one duplicate, leaving a total of 109 citations.

The titles and abstracts of the 109 articles were carefully reviewed for relevance according to the inclusion criteria: (a) volunteers; (b) healthcare volunteers; and (c) retention. The exclusion criteria employed by the PM eliminated children and teenage participants. The full

text was retrieved for all articles that met the criteria, and then they were reviewed for final eligibility.

Evidence Search Results and Evaluation

A search of CINAHL resulted in 69 articles, PubMed 64 articles, and MEDLINE 10,000 articles, for 10,133 articles. Limiting the search to publications from 2015 to 2020 in the English language brought 109 articles. A review of the articles and titles was completed, which left 21 articles. The PM developed a PRISMA model (Moher et al., 2009) for the 21 articles included in the proposed EBP change project (see Figure 1).

The articles selected were identified as a global view of volunteer organizations struggling with retention of HVs. The evidence level and quality guide chosen to appraise the articles was the Johns Hopkins Nursing Evidence-Based Practice or JHNEBP (Dang & Dearholt, 2017). The JHNEBP evidence levels ranged from Level I to V, and each article was assigned a quality grade (Dang & Dearholt, 2017).

The evidence of the 21 articles ranged from Level I to II, and they were consistently A or B quality (see Appendix D). A theme-based intervention for the HVRP was supported. The PM studied the ARC website to establish an overview of the organization. The PM also reviewed the AHRQ and Institute for Healthcare Improvement websites to identify relevant quality tools.

Synthesis of Literature Review

A synthesis of the literature found evidence to support a critical need for retention of HVs. Results from the studies worldwide depicted the challenges organizations have competing for HVs in times of disasters and other humanitarian missions. Retention programs were suggested to support and mobilize volunteers for long-term commitments (Haski et al., 2018; Kim et al., 2019; McGeehan et al., 2017; Omoto & Packard, 2016; Salmani et al., 2019; Sarti et

al., 2017; Smith & Grove, 2017; Wilson & Son, 2018). Researchers around the world recommended exploring factors affecting retention of CBHVs and CHWs to support humanitarian aid (Afari-Asiedu et al., 2018; Albuquerque et al., 2018; Chatio & Akweongo, 2017; Mays et al., 2017; Mlotshwa et al., 2015; Ngugi et al., 2018; Vareilles et al., 2015).

Themes

A careful review of the literature resulted in three major themes: mentoring, education and training, and social support. These themes were described in a context of operational functions related to the preparedness, response, and retention phases for long-term volunteer commitment (Albuquerque et al., 2018; Salmani et al., 2019; Wilson & Son, 2018).

Mentoring

Findings in the literature showed the importance of social environments that eased and supported field missions by strengthening retention strategies (Albuquerque et al., 2018). Social support in the volunteer organization came in the form of a mentor who provided guidance and support through volunteering. An example was when a new volunteer reached out to a mentor who explained a process or a change that otherwise could have caused frustration and dissatisfaction. According to several studies in Africa, supportive supervision and feedback occurred during mentoring and led to community acceptance (Afari-Asiedu et al., 2018; Albuquerque et al., 2018; Chatio & Akweongo, 2017; Mlotshwa et al., 2015; Ngilangwa & Mgomella, 2018; Ngugi et al., 2018; Salmani et al., 2019). A positive experience with a training lead or mentor improved volunteer retention chances (Salmani et al., 2019).

In Africa, Canada, Sweden, and the United States, HVs were motivated by a mentor who reinforced the mission's goals and by the value of altruism to render aid to others in time of serious need during disasters (Afari-Asiedu et al., 2018; Albuquerque et al., 2018; Chatio &

Akweongo, 2017; Kim et al., 2019; Mays et al., 2017; McGeehan et al., 2017; Mlotshwa et al., 2015; Moghaddam et al., 2018; Ngilangwa & Mgomella, 2018; Ngugi et al., 2018; Sarti et al., 2017; Smith & Grove, 2017; Vareilles et al., 2015). According to O'Donohue et al. (2015), volunteers fulfilled the organizational obligation, sustained functional relationships, and enhanced performance and productivity by making a socio-emotional commitment to their supervisor or mentor.

Education and Training

Preparation for many CHWs came from individual experiences; however, education and training for role definition were important for the CHWs during onboarding, especially before a disaster response (Mlotshwa et al., 2015). While job inductions may be complex, a lack of clear process or guidance related to inadequate training can overwhelm the volunteer (Mlotshwa et al., 2015). New CHWs may struggle with role identity, which could pose a challenge during a real disaster (Mlotshwa et al., 2015). The literature showed CHWs wanted ongoing training and acquisition of knowledge through refresher courses in the community (Afari-Asiedu et al., 2018; Albuquerque et al., 2018; Chatio & Akweongo, 2017; Mlotshwa et al., 2015; Ngilangwa & Mgomella, 2018; Ngugi et al., 2018; Salmani et al., 2019). A strategic plan was suggested to create a structured retention program for engagement (Salmani et al., 2019).

In the VFI, the volunteer's career-building view was another motivator for volunteering (Alfes et al., 2017; Clary et al., 1998). Professional collaboration and knowledge sharing increased confidence and competence while volunteers integrated into the mission-ready culture of serving. Community recognition was also important for many volunteers (Afari-Asiedu et al., 2018; Albuquerque et al., 2018; Chatio & Akweongo, 2017; Mlotshwa et al., 2015; Ngilangwa & Mgomella, 2018; Ngugi et al., 2018; Salmani et al., 2019). Although the organization may offer

a structured education plan, some HVs did not understand the engagement rules and dropped off the volunteer list due to failure to follow specific guidelines and requirements. Continuous engagement keeps HVs informed and active.

Social Support

A shortage of formal healthcare workers has left many rural communities neglected. The use of CBHVs to sustain healthcare activities has been effective, and the challenge to retain them was met by community support, incentives, and fulfilled logistical needs (Chatio & Akweongo, 2017). A good example was the request that the CBHVs made for simple items (such as raincoats, torch lights, boots, and bicycles) as retention mechanisms (Chatio & Akweongo, 2017). These individuals remained engaged and motivated by their desire to help the community while balancing their logistical needs with social support (Chatio & Akweongo, 2017).

The healthcare volunteer, a socially integrated being who accepted volunteering through socialization and neighboring, benefitted from social support (Wilson & Son, 2018). Socialization and bonding within the organization affected the volunteer's intent to stay and their availability during disasters (Albuquerque et al., 2018). Communication, trust, and social bonding are integral to the volunteer relationship for retention, intent to stay, and volunteer satisfaction (Alfes et al., 2017; Clary et al., 1998; Salmani et al., 2019). Transformative volunteering is about enhancing motivation (Ortega Carpio et al., 2018). Communicating cultural and ethnic diversity is essential to social support (Meyer et al., 2016).

Practice Recommendations

After a careful review of the scientific evidence, the practice recommendation for this EBP project answered the PICOT question with the development and implementation of the HVRP (Salmani et al., 2019). The results from the evidence and grading are found in Appendix

D. The themes (see Appendix E) strongly recommended mentoring, education and training, and social support for the retention of HVs. The evidence, according to JHNEBP, Level I and II articles with grades of A and B, demonstrated similar themes related to mentoring, education and training, and social support (Albuquerque et al., 2018; Dang & Dearholt, 2017; Salmani et al., 2019; Wilson & Son, 2018). The development, implementation, and evaluation of the HVRP included the preparedness phase in which a mentor was assigned for education and training; a response phase for competency with continued mentor support; and a retention phase of social support. Compliance with the HVRP was monitored and reported to stakeholders. Ongoing briefings and education on the HVRP were also documented.

The evidence supported the HVRP necessary for the retention of HVs. The IVO's mission is the prevention and alleviation of suffering, which may be carried out with the mobilization and "power of volunteers" (ARC, 2020a, para. 1). The benefits of volunteering included a decreased risk for depression, a better sense of physical and mental health well-being, and improved social engagement and support (Nothwehr & Rohlman, 2019). Furthermore, building trust, fostering a culture of collaboration, and building self-confidence during a steady state was important for retaining HVs (Salmani et al., 2019). Salmani et al. (2019) stressed the importance of having plans at the operational level and supported requirements in the preparedness phase to include education and training; mentoring in the response phase for supportive supervision; and a need to address retention by implementing plans for follow-up of physical and mental health after a mission. Volunteers work alongside paid employees; therefore, management must have a keen understanding of keeping volunteers engaged and supported (ARC, 2019a). The leadership approved the recommendation to implement the HVRP at this IVO.

Project Setting

The project setting for this EBP project was an IVO that covered HVs from the Southeast and Deep East Texas, Greater Houston, Coastal Bend, and South Texas (ARC, 2020c). The regional headquarters office is in Houston, Texas. HVs accessed their chapter through virtual modalities such as the Microsoft (MS) Teams website application and Volunteer Connection (VC). The region is proud to serve the community with various missions such as Disaster Services, Service to Armed Forces, International Services, and Preparedness Health, Safety, Development, and Volunteer Opportunities (ARC, 2020c). The IVO has board officers and elected board members with regional and chapter leaders in collaboration with local and corporate partners (ARC, 2020c).

Clients

A typical client at the IVO could have come from any age, ethnic, cultural, and financial background. The client may have been healthy or had multiple co-morbidities with varying types and degrees of disabilities. Some victims of disasters suffered the loss of durable medical equipment and medications, while others struggled with the disaster situation itself and required mental health referrals (Abbott, 2019).

Organizational Structure, Culture, and Need

The IVO professed to have a strong employee and volunteer engagement (ARC, 2020c). Readiness for change was accepted by leadership. The organizational structure supported a strong workforce of human resources, data infrastructure, management, and logistic support. The organization's reputation as a community resource is one of its' demonstrated strengths (Abbott, 2019; ARC, 2020c). The IVO leadership follows a territorial or chapter, regional, divisional, and national structure (ARC, 2020b).

The IVO offered virtual and in-person education and training to the staff, volunteers, and the community. However, in-person education was restricted during the COVID-19 pandemic of 2020. The organization valued cultural diversity by proving its commitment to openness and inclusion for all staff, volunteers, and clients (ARC, 2020a). The organization also supported international missions to Mexico and other countries as an international resource. Virtual deployments were available for individuals who had the skill sets to volunteer in specific areas such as mental health, spiritual care, and some health services.

According to a conducted needs assessment and gap analysis, the retention of HVs was a problem at the IVO. A completed Fishbone Diagram showed a lack of structured process for onboarding, mentoring, and offering growth opportunities for new HVs (Association of Quality, 2019). These results determined that a lack of standardization was evident for mentoring, education and training, and social support to retain HVs in this organization and identified a need for an EBP project to be planned, implemented, and evaluated to create positive change.

Organizational Support, Stakeholders, and Sustainability

The IVO leadership expressed a need to improve the retention of HVs. Additionally, a healthcare chapter leader was the preceptor for the PM and supported the DNP scholarly project. The IVOs leadership key stakeholders were the Regional Disaster Health Service Lead (RDHSL) and chapter leaders. The RDHSL had authority and supervision for the compliance of healthcare volunteer mentors to implement the HVRP. Briefings and education were afforded with the support of leadership. Other stakeholders included chapter leaders and supervisors from other departments, such as volunteer engagement.

Support was evident throughout the collaborative engagement of HVs from the IVO. Client satisfaction was at stake due to the scarce resource of HVs to ensure the safety and

wellness of clients displaced by a disaster. The facility leadership supported the sustainability of the HVRP for the management of HVs. The chapter leaders were actively involved with the RDHSL and PM for the implementation of the HVRP. The mentor's compliance with the implemented HVRP was imperative to its success. The HVRP implementation was monitored and documented using the HVRP form (see Appendix A). This project was also sustained by continuously educating new and existing HVs about the HVRP process (Smith & Grove, 2017).

Interprofessional Collaboration

The interprofessional collaboration within the IVO was needed for the sustainability of this EBP project plan. The RDHSL had oversight of HVs and mentors. The RDHSL and PM met with the mentors monthly to ensure the mentors fulfilled their HVRP implementation responsibility.

The Strengths, Weakness, Opportunities, and Threats Analysis

A strengths, weakness, opportunities, and threats analysis, referred to as SWOT, was conducted to identify issues and establish strategies to meet the organizational need for a project plan (AHRQ, n.d.-a). The facility's strengths included its mission, vision, core values, and pillars with a guiding philosophy. Another strength was their history, which stretched back to 1881 when Clara Barton founded the ARC (ARC, 2020b). Barton provided aid to soldiers during the Civil War in the early years of 1881, and the IVO has since been respected internationally for responding to disasters (ARC, 2020b). The IVO has a strong and esteemed public image in the community. Other strengths included technology, resources, and leadership support (see Appendix F).

The internal weaknesses were the reduced healthcare volunteer participation and a lack of structured mentoring, education, and training. Opportunities existed for collaboration with local

healthcare organizations and colleges during disaster relief efforts. Finally, the threats to this organization included healthcare volunteer resources being exhausted due to long-standing disaster relief missions and multiple ongoing disasters (Abbott, 2019).

Project Overview

The purpose of this EBP project was to compare how the implementation of the HVRP that included mentoring, education and training, and social support influenced healthcare volunteer retention rate, intent to stay, and volunteer satisfaction 12 weeks after HVRP introduction.

The Project Vision and Mission

The vision and mission conveyed the purpose of the EBP project, objectives, and goals. Together, the vision and mission guided the participants' adherence to the intervention's support and sustainment. This EBP project's vision was client access to the delivery of care by HVs during a disaster response. This EBP project's mission was to successfully implement the HVRP and influence the retention rate of HVs, their intent to stay, and overall volunteer satisfaction. This vision and mission were parallel to those of the IVO (ARC, 2020a).

Objectives, Risks, and Unintended Consequences

The objectives, short-term goals, and long-term goals guided this EBP project. The short-term goals of this EBP project included: 1) to implement the HVRP by July 2020; 2) to influence the healthcare volunteer retention rate; 3) to improve the intent to stay by 5% in over 12 weeks from HVRP introduction; and 4) to improve healthcare volunteer satisfaction by 5% in over 12 weeks. A long-term goal is to disseminate the planned intervention of the HVRP to the national level of the IVO within the following year. Another long-term objective is to offer this HVRP to other volunteer organizations through the next three years' annual conventions.

The PM used a risk matrix tool to find risks. The strategy was to address the risks with the highest score. The interprofessional team approach was used to address risks and unintended consequences and proved helpful in this assessment and for this project's success. Training of the mentors and HVs was essential to begin the behavior change. A well-defined plan was considered, prepared, and implemented to address operational issues such as a shortage of mentors, resistance to change, internet interruption or failure, and other associated technical issues.

Limitations included volunteer shortages related to unavailable HVs affected by the COVID-19 pandemic of 2020 and the environmental stressors. Supervisors worked diligently with each other to ensure that the disaster response was uninterrupted. Interprofessional collaboration occurred at all stages of the HVRP intervention. Clear and concise communication was focused on the mission. The chapter leaders helped with the change process and addressed any resistance issues due to volunteer shortages.

Project Plan

The IMC guided the EBP project plan with the PDSA process (AHRQ, 2018; IMC, 2017). The IMC approach is systematic and links EBP practice changes within a system (IMC, 2017). The PDSA model (AHRQ, 2018) linked the elements of using the HVRP for the management of HVs. The description of the implementation plan, schedule, and budget are necessary to summarize the details of the EBP project plan or method used.

Lewin's Change Management Model

Kurt Lewin's change model was a guide for this EBP project, and it identified barriers to change using the three-stages: unfreezing, moving, and refreezing (Lewin, 1947). The expected change was the acceptance of the HVRP implementation by the staff and HVs of the IVO.

Unfreezing Stage

During the unfreezing phase (Lewin, 1947), the IVO's HVs were in a state of awareness, recognized the shortage of volunteers, and understood the urgency of a retention program. The PM and IVO key stakeholders organized an interprofessional team that included HVs and chapter leaders from the health services. Early communication was important to discuss challenges, barriers, and strategies to define the project's direction.

Moving Stage

During the moving stage (Lewin, 1947), the project's implementation occurred with the support of IVOs leadership. The RDHSL and PM monitored the schedule, education, and volunteer response, which was central to the project's success. Clear communication of the implementation plan had to occur, and an opportunity for questions and concerns was granted to ensure compliance and sustainability.

Refreezing Stage

The refreezing stage (Lewin, 1947) allowed a time for stability and reflection on the implementation. A continuous effort was made to support the goals of influencing retention rates, intent to stay, and overall healthcare volunteer satisfaction. Education and briefings continued to benefit the HVs. Once the implementation was completed, the process was evaluated, summarized, and reported to the stakeholders to describe the challenges, successes, and goals achieved.

The Intervention

The IVO leadership identified a threat in retaining HVs and communicated the issue while assessing the organizational needs. The IMC served as a guide and framework with the PDSA process to test a change at the IVO with the implementation of the HVRP for this EBP

project (AHRQ, 2018; IMC, 2017). The intervention was the HVRP. The observed outcomes were the retention rate, intent to stay, and overall volunteer satisfaction post-implementation. These outcomes were compared using the VFI post-implementation survey scores compared to the VFI pre-implementation survey scores.

The statistical analysis outlined the outcomes of the VFI pre- and post-implementation surveys. Outcomes and data were observed and collected before the implementation to analyze the effectiveness of the intervention. VFI pre- and post-implementation surveys were analyzed, and the results were reported to the stakeholders. The barrier to change was a lack of knowledge. The PM was available as a resource and provided education and awareness. The interprofessional collaboration was evident throughout the IVO. The PM displayed patience and respect during this process to affect the change process.

During the Plan step of the PDSA model (AHRQ, 2018), the PM and RDHSL coordinated the interprofessional team and EBP project champions to orchestrate the implementation plan. The RDHSL had the authority to make decisions related to health services and was a resource for identifying barriers and facilitators to ensure the EBP project progressed as planned. The RDHSL was involved in the educational plan and training for the mentors. The RDHSL also assisted the PM in collecting and analyzing the data. Formative assessments were also used to ensure continuous improvements to the EBP project.

Key players had to agree to their assigned role during the planning stage for this EBP project to be successful. The interprofessional meeting took place with the stakeholders. The RDHSL and PM collected baseline data of new and existing HVs at the IVO and reported them to the stakeholders. Next, the PM met with the RDHSL to review the HVRP for implementation.

During the Do step (AHRQ, 2018), the PM sent a communication by email to the HVs to introduce the HVRP. The PM, acting as a resource, scheduled an appointment with the RDHSL to provide education to the staff and HVs about the HVRP at the following monthly meeting. Next, the PM distributed the VFI pre-implementation survey to the HVs. Finally, in collaboration with RDHSL, the PM educated the mentors on using the HVRP; then, the implementation began with new and existing HVs (Alfes et al., 2017; Clary et al., 1998; Kim et al., 2019). The HVRP was used as a formative evaluation.

Then, during the Study step of the PDSA (AHRQ, 2018), the data collection occurred and guided the evaluation. The PM collected, reviewed the results, analyzed, and reported findings from the VFI pre-implementation surveys to the stakeholders. The PM administered the VFI post-implementation survey to the HVs at the end of the 12 weeks from the HVRP introduction; then, reviewed the survey results, analysis, evaluation of the implementation, and reported to the stakeholders (Alfes et al., 2017; Clary et al., 1998; Kim et al., 2019). A bar chart was used to display the results shared with the stakeholders. The PM reported cost issues to the stakeholders twice during this EBP project to keep the stakeholders informed. Finally, the PM collected the outcome data; with assistance from a statistician, the PM compared the baseline, VFI pre- and post-implementation data; evaluated retention, intent to stay, and satisfaction; then reported those results to the stakeholders.

Finally, based on the VFI results, a collaboration occurred during the Act step of the PDSA (AHRQ, 2018), and modifications were made to improve areas of the HVRP. The results were analyzed to determine the HVRP met the objective to influence the retention rate for HVs, the intent to stay, and volunteer satisfaction. The results supported the sustainability of the

HVRP, and preparations began to disseminate this EBP project locally at the IVO, regionally, and then nationally. The final summative evaluations were explained to the stakeholders.

Barriers and Facilitators

Barriers and facilitators are part of EBP projects. One barrier in this EBP project was related to volunteer shortages caused by a demand for formal healthcare workers during the pandemic of 2020. Another barrier was the lack of knowledge in the latest technology and the adopted systems because of the restrictions related to social distancing and the environment. HVs had trouble navigating the electronic system. Leadership support is the best type of facilitator for this organization. Leadership monitored efficiency and compliance of the intervention. The behavior change was led by the RDHSL and followed by the HVs.

Project Schedule

The EBP project proposal was first submitted for review by the Evidence-Based Practice Project Review Council (EPRC) from the University of St. Augustine for Health Sciences (USAHS) before implementation. The purpose of the EPRC was to review the DNP scholarly EBP project proposal to ensure a reflection of the knowledge will be used and transferred to other programs within the organization. Once the EPRC approval was granted, the EBP project proposal was submitted to the IVO leadership for review and approval.

After obtaining approval from the USAHS and the IVO, the PM met with the IVOs leadership team to share the approval and discuss the EBP project implementation dates and projected budget. Next, the PM collected the baseline data of new and existing HVs at the IVO. Then, the PM reviewed the HVRP with the RDHSL, sent an email with written notification of EBP project implementation to the HVs, and RDHSL introduced the HVRP at the staff meeting.

The PM re-created a pre-implementation survey using the VFI in the MS Forms application (Clary et al., 1998). The VFI is a validated tool with high reliability (Chacon et al., 2017). The PM administered the VFI pre-implementation survey to the HVs. The HVs received an email with the link accessing the survey for completion (see Appendix C). The volunteers' IVO assigned identification number was used to match the VFI pre-and post-implementation surveys for comparison. The surveys were voluntary, and the potential for harm was minimal. The results of the surveys were analyzed and reported to the stakeholders. The PM was a resource and provided education to the mentors and HVs. Once the training was complete, the PM began the EBP project intervention. In collaboration with the RDHSL, the PM collected data of new HVs during the implementation and acted as the point of contact for the workgroup while coordinating any changes and requests for changes.

The PM administered the VFI post-implementation survey 12 weeks from the HVRP introduction and collected the results from the HVs by extracting the information using an MS Excel worksheet for input into the IBM Statistical Package for Social Sciences (SPSS) version 23. The PM removed any personally identifiable information from the Excel worksheet results and emailed it to the statistician to analyze the survey outcome data. The data were analyzed using SPSS 23. The cost incurred was reported to the stakeholders twice during this EBP project. Once all the data had been analyzed and documented, the PM prepared and offered a presentation to the stakeholders. See Appendix G for the EBP Project Schedule.

Budget and Resources

The resources required for this EBP project have indirect costs. HVs are not paid; therefore, there was no direct cost. The budget was presented to the leadership of the organization for review. Resources used included virtual modalities accessed by HVs at their

cost. Educational material was electronic, and printing was not needed unless each volunteer chose to print. A \$5 gift card for survey participation was issued to each volunteer per survey completed and totaled \$145. Other expenses included cards and stamps for mailing the gift cards. Total expenses were \$168 (see Table 1).

Project Management Role and Leadership Skills

The PM had a significant role in this high impact EBP project and had to demonstrate to be flexible, adaptable, and a good communicator, which are leadership skills crucial to lead and guide the team within the budgetary goals, the scheduled time frames, and understand the scope for implementation to reach the objectives. The PM's responsibility was to encourage and motivate the interprofessional team to move the EBP project into an atmosphere conducive to teamwork.

Results

Data collection and analysis were vital to the success of this EBP change project. The IVO had 91 team members who participated in implementing a formal HVRP in June 2020 after approval from the EPRC of the USAHS and IVO that same week. This section includes data collected along with an analysis and discussion of the results.

The PM collected baseline data of new and existing HVs at the IVO DHS. The PM and statistician used the IBM SPSS 23 to identify the EBP project outcomes' statistical significance with a paired *t*-test that compared VFI pre- and post-implementation survey results. The independent variable was the introduction of the HVRP. Dependent variables were the retention rate, intent to stay, and volunteer satisfaction.

The sustainability measure was the percent of HVs enrolled in the HVRP (see Appendix H). Figure 2 shows the participants' frequency and percentage distribution by chapter group and

the total number of participants. Green bars indicate the frequency, and blue bars indicate the percentage. There were 91 participants. The IVO headquarters is in Houston, Texas, which accounted for 82% of the participants.

Figure 2

Frequency and Percentage Distribution of Participants by Chapter Group

Years of service is an influential factor in the retention of HVs. Figure 3 contains the frequency and percentage distribution of participants by years of service group. Green bars signify frequency, and blue bars signify percentage. There was a total of 91 participants. The calculated mean age was 3.32, and the standard deviation was 8.15. Two participants who dropped off the volunteer list were within the 5 years and below service group. The reasons for dropping off the volunteer list included: relocation to another region, going back to college, and secular work demands.

Figure 3

Frequency and Percentage Distribution of Participants by Years of Service Group

Another strategy was to analyze participants by county. Figure 4 contains the frequency and percentage distribution of participants by county group and the total number of participants. Green bars signify frequency, and blue bars signify percentage. There was a total of 91 participants.

Figure 4

Frequency and Percentage Distribution of Participants by County Group

During the Do step of the PDSA (AHRQ, 2018), the RDHSL formally invited the HVs to a DHS Orientation. The DHS Orientation was added to the DHS Training Calendar for registration. HVs had access to register for classes in VC. The process measure was the percent of trained mentors (see Appendix H). In this EBP project, 100% of the mentors were trained.

The VC was used to send a group email with the survey link to participants. Participants were asked to enter their IVO assigned number or name to match the VFI pre- and post-implementation survey results. They were also reminded that the facility leadership approved the survey; it was voluntary, and that their name and email address would not be shared. The potential for harm was minimal and included personal time (8-10 minutes) to complete each survey.

The VFI pre-implementation survey return rate was 18, or 20% (n=91). The VFI post-implementation survey return rate was 18, or 20% (n=91). Thirteen participants or 14% (n=91) completed both VFI pre- and post-implementation surveys. The PM identified two issues that caused poor survey participation. First, since the survey link was not active within the email, participants had to copy and paste it into a web browser. Secondly, the email with the survey link was going into the participant's "Junk" folder and was missed as reported by the HVs during a staff meeting. The RDHSL sent a second email with a survey link to the participants. The PM collected and extracted results of the VFI pre-implementation surveys using an MS Excel worksheet. Results were then analyzed and reported to the stakeholders.

The PM and RDHSL collected and stored the data using password protection to maintain survey integrity. The PM replaced the HVs names with the IVO assigned numbers and matched the VFI pre- and post-implementation survey results. The VFI pre- and post-implementation surveys that did not match each other were given a consecutive identifying number for analysis

that was not paired. HVs personally identifiable information was removed before the Excel worksheet analysis, and the final document was copied into a new Excel worksheet identifying each HV with a number. Participants' rights were protected.

During the Study step of PDSA (AHRQ, 2018), the PM received reports of a lack of participant interest when the mentors texted, called, and emailed them to engage in volunteer activities and register for the DHS Orientation. Participants who did not attend the DHS Orientation were invited several times. Figure 5 shows the frequency and percentage distribution of their engagement in the last 180 days. The total number of participants was also included in the table. Green bars indicate the frequency, and blue bars indicate the percentage. Figure 5 shows 74 (81%) participants were Yes for their engagement in the last 180 days, and 17 (19%) participants were No for the lack of engagement in the past 180 days. There were 91 participants.

In comparison, Figure 6 shows the participants' frequency and percentage distribution of their engagement in the last 30 days. The total number of participants was also included in the table. Green bars indicate the frequency, and blue bars indicate the percentage. As shown in Figure 6, 57 (63%) participants were Yes for their engagement in the past 30 days, and 34 (37%) participants were No due to lack of their engagement in the 30 days. There were 91 participants. The percentage of those who were not engaged in the last 30 days was twice as almost high as the comparative figure within the last 180 days (Figure 5). A busy storm season and the COVID-19 pandemic of 2020 negatively impacted the HV participants' engagement, as reported at the DHS staff meetings. The RDHSL reminded the HVs during the staff meetings to enter volunteer hours in the VC and recommended that this reminder become part of the monthly checks to prevent HVs from dropping off the volunteer list due to lack of recorded hours.

Figure 5

Frequency and Percentage Distribution of Participants by Last 180 Days Engagement Group

Figure 6

Frequency and Percentage Distribution of Participants by Last 30 Days Engagement Group

During the Act step of PDSA (AHRQ, 2018), the PM met with stakeholders, and a discussion ensued to revise the HVRP. The revised HVRP shown in Appendix A was shared with stakeholders. The HV and mentor have specific tasks related to each phase of the HVRP that may be individualized for each HV. Consistent communication is important to the engagement and overall retention of the HVs.

The outcome measure (explained in Appendix H) may be viewed in Figure 7, which shows the survey participants' frequency and percentage distribution of intent to stay before

implementing the HVRP. The total number of survey participants was also included in the table. Green bars indicate the frequency, and blue bars indicate the percentage.

Figure 7

Frequency and Percentage Distribution of Participant's Intent to Stay Before the HVRP

Figure 8 shows the survey participants' frequency and percentage distribution intent to stay after implementing the HVRP. The total number of survey participants was also included in the table. Green bars indicate the frequency, and blue bars indicate the percentage. As shown in Figure 8, 18 (100%) survey participants answered that they would be volunteering at this organization. There was a 6% improvement in the intent to stay by the HVs, which exceeded the outcome measure goal by 1% (see Appendix H). There were 18 survey participants.

Figure 8

Frequency and Percentage Distribution of Participant's Intent to Stay After the HVRP

The balancing measure was the percent of HVs satisfied with the HVRP. Figure 9 shows the participants' frequency and percentage distribution by HVs satisfaction in the HVRP. The total number of participants was also included in the table. Green bars indicate the frequency, and blue bars indicate the percentage. Overall, the 16 survey participants, based on the data, were satisfied with the HVRP.

Figure 9

Frequency and Percentage Distribution of Participant's Satisfaction in the HVRP

Outcome measures included a retention rate per 100 for HVs at the IVO. Figure 10 shows the frequency distribution by retention rate. Two volunteers dropped off the list. The retention rate was 98%. Therefore, more than 50% of the HVs were influenced by HVRP.

Figure 10

Frequency of Retention Rate

As shown in Table 2, a paired-samples *t*-test compared the results of the VFI pre- and post-implementation surveys. The VFI pre-implementation survey had a calculated mean of 142.91 and a standard deviation of 37.98. The VFI post-implementation survey had a calculated mean of 218.38 and a standard deviation of 65.54. The resulting *t*-value of 3.508 at $\alpha = .05$ showed a statistically significant difference, suggesting the HVRP implementation was effective for HVs.

Table 2

VFI Pre- and Post- HVRP Implementation Paired Sample Statistics

<i>Variables</i>	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>Df</i>	<i>t-value</i>	<i>p-value</i>
Pre-implementation	13	142.92	37.98	12	3.508	0.004
Post-implementation	13	218.38	65.54			

Significant at the 0.05 level (2-tailed).

Impact

The primary outcome addressed by this EBP project was the development, implementation, and evaluation of a retention program with the Preparedness, Response, and Retention Phases. Three themes emerged from the evidence: mentoring, education and training, and social support. These themes influenced the retention of HVs, their intent to stay, and satisfaction with the HVRP (Albuquerque et al., 2018; Salmani et al., 2019; Wilson & Son, 2018). Social support in the form of a mentor for guidance within the IVO allows for the acquisition of knowledge through ongoing training and sharing of volunteer experiences with supportive supervision, feedback, and engagement through meetings, award ceremonies, networking for socialization and bonding that affects their retention, intent to stay, and

satisfaction (Afari-Asiedu et al., 2018; Albuquerque et al., 2018; Chatio & Akweongo, 2017; Mlotshwa et al., 2015; Ngilangwa & Mgomella, 2018; Ngugi et al., 2018; Salmani et al., 2019).

The EBP project improved practice for the IVOs DHS group by implementing a process in which HVs are assigned and meet with their mentor during the DHS Orientation. The practice change includes mentors who are trained in the HVRP. The HVs and leadership easily accepted the HVRP due to the cost-effectiveness and ease of implementation. Although only two participants volunteered to be mentors for this project period, a total of seven participants volunteered to be mentors at a future time, which gave a sense of a lasting effect by the HVRP.

Several issues were identified with the recruitment of mentors. HVs reported that they were busy with disaster relief operations during the hectic hurricane season. MS Teams application was the latest technology software that challenged most participants. The COVID-19 pandemic of 2020 gave way to more training requirements. Nevertheless, the HVs were dedicated to the mission and vision of the IVO. The study will be replicated and modified for application to the disaster mental health, spiritual care, and disability integration activities in addition to the current results. A meeting has been established with staff to discuss future implications on a local and regional level.

As presented in Figure 3, 82 (90%) participants belonged to the 5 and below years of service group. These results indicate the importance of retention strategies, especially for those in the 5 and below years of service group. Closing the retention gap between the 5- and 10-year service groups is necessary to sustain HVs in the organization, which is best applied with the HVRP.

Hurricanes Hanna and Laura impacted the IVO during the implementation of this EBP project and was reported to have had property damages and losses beyond the capabilities of

local and state governments, which was also compounded by a COVID-19 environment which required HVs to adhere to state and local regulations and mitigate exposures while attending medical needs of the disaster-stricken evacuees (Cornyn, 2020). Additionally, due to the hurricanes and 2020 pandemic, the virtual environment created an opportunity for added resources to be established. Other benefits are the inclusion of a scheduled discussion of the HVRP at each monthly meeting and annual training to improve the practice problem further and sustain the intervention. Evaluation of the effectiveness of the HVRP may also be integrated into the quarterly leadership meetings and annual strategic planning.

Plans for Dissemination

The dissemination strategies have been and continue to be formal and informal to suit the specific audience and intended purpose. Peer review was used to evaluate the HVRP and occurred at the local level with the interdisciplinary team, mentor, advisor, statistician, and writing coaches. Further peer review will be needed before manuscript dissemination in professional journals and organizations.

Briefings, summaries, and implementation guidelines were used to communicate results with stakeholders and HVs. A PowerPoint presentation describing the practice change of the HVRP was produced for the local and regional IVO. Representatives from this organization will use the presentation to inform new HVs. To enhance project sustainability, the HVRP is included in the DHS Orientation and monthly meeting agenda for new and existing HVs. A plan is in progress to replicate the HVRP and expand to other IVO activities. The EBP project will be submitted to the Scholarship and Open Access Repository website at the University of St. Augustine for Health Sciences. A link to the record page in SOAR@USA will be added to the author's social media account. Future students will be able to access the DNP scholarly project

using the same link. Finally, a plan to publish in the *Nonprofit and Voluntary Sector Quarterly* is appropriate to reach leaders and members of volunteer organizations. Publication of the EBP project results will increase reader awareness of the HVRP benefits and retention determinants: mentoring, education and training, and social support through the Preparedness, Response, and Retention Phases.

Conclusion

The threat of hurricanes, fires, and other world disasters continue to plague humanity. (Keim et al., 2019). The pandemic of 2020 was a public emergency that challenged HVs in all capacities worldwide during this EBP project. Future opportunities to explore include collaboration with local healthcare organizations and colleges for event-based volunteers during disaster relief efforts. Healthcare volunteer response readiness implicates a need for retention to focus on mentoring, education and training, and social support (Salmani et al., 2019). Retention of this workforce is vital when responding to the health and wellness of the community, our country, and the world.

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Smith, S. L., & Grove, C. J. (2017). Bittersweet and paradoxical. *Nonprofit Management & Leadership*, 27(3), 353–369. <https://doi.org/10.1002/nml.21250>

Trevizo, P. (2020). Holistic Houston: In the wake of Hurricane Harvey the city is redefining its approach to resilience planning. *Planning*, 86(1), 30.

Vareilles, G., Marchal, B., Kane, S., Petrič, T., Pictet, G., & Pommier, J. (2015). Understanding the motivation and performance of community health volunteers involved in the delivery of health programmes in Kampala, Uganda: A realist evaluation. *British Medical Journal open*, 5(11), e008614. <https://doi.org/10.1136/bmjopen-2015-008614>

Wilson, J., & Son, J. (2018). The connection between neighboring and volunteering. *City & Community*, 17(3), 720–736. <https://doi.org/10.1111/cico.12324>

Table 1*Budget*

Expenses	Cost	Description
Indirect costs		
Training	\$0.00	Volunteers are non-paid workers
Supplies	\$23.00	Cards, envelopes, and stamps
Gift Cards	\$145.00	\$5.00 for each survey completed
Total Expenses	\$168.00	

Figure 1*Healthcare Volunteer Retention Program*

Moher, D., Liberati, A., Tetzlaff, J., Altman, D.G., & The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement*. *PLoS Med* 6(7), e1000097. <https://doi.org/10.1371/journal.pmed.1000097>

Appendix A

Healthcare Volunteer Retention Program

Volunteer Name	Mentor Name
Phone number/email	Phone number/email
Chapter/Region	Chapter/Region
Date Started Assignment	Assignment

Purpose

This program will guide the mentor and volunteer in navigating through the preparedness, response, and retention phases of the volunteer service to influence retention, intent to stay, and volunteer satisfaction. This healthcare volunteer retention program (HVRP) is to be used in collaboration with the organization's existent volunteer handbook, standards and procedures, job descriptions, and career path and training job tools. Mentoring during these three phases is vital to the retention program.

- A. Preparedness Phase: Onboarding, education, training, and competency are vital to the success of the healthcare volunteer.
 1. A mentor is assigned at the beginning of this phase to guide the volunteer through the completion of important tasks.
 2. The first meeting with the volunteer for the welcome and service station orientation will occur within 1-2 weeks.
 3. The mentor will review tasks within the Preparedness Phase during the first 30 days.
 4. The Preparedness Phase sets the foundation for self-confidence during the response phase.
- B. Response Phase: Mentoring produces a well-prepared and informed volunteer who is disaster-ready.
 1. The volunteer discloses the engagement schedule, plans activities, and reviews the workload.
 2. The volunteer has the necessary tools, training, resources, and opportunities to improve the volunteer experience during this phase.
 3. Feedback from the mentor is an important part of evaluating the volunteer's performance during a response mission. This is a two-way conversation.
 4. During the Response Phase, the volunteer may decide to improve the performance within the assigned position or develop a new skill set.
- C. Retention Phase: Social Support is vital to the health and well-being of the volunteer.
 1. A review of the Work-Life-Volunteer Balance is important for wellness.
 2. A discussion about promotion opportunities within the organization and the next steps allows the volunteer the autonomy to make decisions on their volunteer career path.
 3. Social Support is evident within the workgroup or is explored.
 4. A review of the types of recognition and rewards within the organization allows the volunteer to feel appreciated
 5. Personal growth and development are discussed with the volunteer.
 6. Planning for the end of volunteer service is also important for succession planning

7. Annual Training, Evaluations, and new trainings are a continuum to the Preparedness Phase.

Instructions

1. This electronic form intends to guide the volunteer and mentor.
2. This guide has three phases: Preparedness Phase, Response Phase, and Retention Phase.
3. Each phase has a list of tasks. The mentor may adjust and add items to each phase to individualize the program.
4. The volunteer will review each task independently and/or with a mentor and then check each box when complete. Virtual options are available through the organization's technology and email system.
5. The mentor will review each section, offer support, and check the box when complete.
6. This retention program will be reviewed at 30/60/90 days.

Preparedness Phase	Onboarding, education, training, and competency are vital to the success of the healthcare volunteer. Preparedness sets the foundation for self-confidence during the response phase.
Volunteer	☐ Receives a Leadership Welcome ☐ Receives a mentor assigned to ease steps toward the next phase ☐ Attends orientation. ☐ Completes pre-requisites for assignment ☐ Documents monthly volunteer hours
Mentor	☐ Initiates communication with volunteer ☐ Encourages peer collaboration ☐ Checks in at least monthly to review milestones (i.e. submission of volunteer hours, training & technology support, goal setting)

Preparedness Phase	Volunteer	Mentor
Welcome! Get to know your service station.	☐ Welcome contact with the mentor ☐ Introduction to the organization through email, virtually, or in-person ☐ Received Map of Region ☐ Received access and tour the building ☐ Service Station Safety ☐ Understanding the communication system by phone, text, email, and/or other means ☐ Review the use of office equipment ☐ Review the use of fleet ☐ Documentation of volunteer hours	☐
Volunteer Handbook and other pertinent documents.	☐ Review of Volunteer Handbook ☐ Volunteer Policies & procedures ☐ Attire and ID	☐
Register and complete the required trainings.	☐ Training Point of Contact ☐ Registered for training ☐ Completed onboarding training ☐ Reviewed questions/issues/concerns	☐

Preparedness Phase	Volunteer	Mentor
Get to know your organizational structure.	☐ National ☐ Divisional ☐ Regional ☐ Territory/Chapter ☐ Lines of Service	☐
Review your position description, role, responsibilities, team communication, and meet others.	☐ Group _____ ☐ Activity _____ ☐ Position _____ ☐ Supervisor: _____ ☐ Program Manager _____ ☐ My Team _____ ☐ My Tools _____ ☐ Staff Directory received _____ ☐ Team 1 _____ (add as needed)	☐
Explore technology and systems for access and resources.	☐ Volunteer services key terms & definitions ☐ Review computer policies ☐ Access to the organization email ☐ Access to the volunteer portal ☐ Access to volunteer share point ☐ Access the Learning Management System ☐ Customer Portal / Password Self Service	☐
Scheduled Reviews	☐ 30 Day Review ☐ 60 Day Review ☐ 90 Day Review	☐

Response Phase	Transition to the response phase occurs when the mentor-supported volunteer has met the requirements for the assignment.
Volunteer	☐ Receives assignment ☐ Mission Ready ☐ Mission Moments ☐ Documents monthly volunteer hours
Mentor	☐ Monthly communication by text, call, or email ☐ Supports mission readiness and debriefing ☐ Reviews safety, health, and wellness

Response Phase	Volunteer	Mentor
Volunteer planned engagement	☐ Number of planned volunteer days/hours ☐ List of projects or activities ☐ Virtual _____ or in-person _____ ☐ Discuss flexibility, adaptability, & opportunities ☐ Review response services, workload, & support	☐
Logistics Identified need for:	☐ Tools ☐ Training ☐ Resources ☐ Opportunities to improve the experience	☐

Retention Phase	Ongoing promotion opportunities within the organization, personal growth and development, social support, recognition, and rewards are vital to volunteer retention, intent to stay, and satisfaction.
Volunteer	☐ Opportunities to lead/teach/mentor ☐ Steps / Promotions achieved ☐ Involvement in recruitment and retention efforts ☐ Documents monthly volunteer hours
Mentor	☐ Monthly communication by text, call, or email ☐ Introduces volunteer to opportunities to lead/teach/mentor ☐ Discusses promotions ☐ Supports ongoing education, retention, and volunteer satisfaction

Retention Phase	Volunteer	Mentor
Safety, Health, and Wellness	☐ Review safety ☐ Review health ☐ Review wellness ☐ Work-Life-Volunteer Balance	☐
Promotion opportunity	☐ Identify promotion opportunities ☐ Next Steps	☐
Social Support	☐ Events within the organization ☐ Events in the community ☐ Social media	☐
Recognition and Rewards	☐ Personal volunteer recognition preference ☐ Awards/Pins/Certificates ☐ Recognition/Nominations	☐
Personal Growth & Development	☐ Values ☐ Understanding ☐ Enhancement ☐ Career ☐ Social ☐ Protective ☐ Survey	☐
Annual Training	☐ Review annually scheduled training ☐ Attend Year _____	☐
Annual evaluations	☐ Review the evaluation process ☐ Review questions/issues/concerns	☐
New Training	☐ Review new training ☐ Attend Year _____	☐
End of Volunteer Service	☐ Review voluntary termination ☐ If leaving: Reason _____ ☐ Review involuntary termination ☐ Process for exit interview ☐ Review questions/issues/concerns ☐ Survey	☐

Appendix B

Approval Letter for VFI Tool

Sandra Gomez**Wednesday, May 27, 2020 at 10:17:09 Central Daylight Time**

Subject: Re: Permission to use VFI**Date:** Wednesday, May 27, 2020 at 9:16:03 AM Central Daylight Time**From:** Mark Snyder <msnyder@umn.edu>**To:** Sandra Gomez <S.Gomez1@usa.edu>

Dear Sandra Gomez,

You have our permission to use the Volunteer Functions Inventory in your evidence-based project on healthcare worker retention.

We hope your project goes well, and look forward to learning about your findings.

Best wishes,

Mark Snyder

On Tue, May 26, 2020 at 10:08 PM Sandra Gomez <S.Gomez1@usa.edu> wrote:

Sirs,

I hope this email finds you well.

I am writing to request permission to utilize the Volunteer Functions Inventory tool in an evidence-based practice change project called "Healthcare Worker Retention Program: Improving Healthcare Worker Retention in a Volunteer Organization"

Very Respectfully,

Sandra Gomez, MSN, RN

Post-Professional Student

MSN to DNP

University of Saint Augustine for Health Sciences

School of Nursing

Email: s.gomez1@usa.edu

Cell: 956-292-1587 (CST time zone)

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Mark Snyder
McKnight Presidential Chair in Psychology
Director, Center for the Study of the Individual and Society
University of Minnesota
75 East River Road
Minneapolis, MN 55455

(612) 625-1507 (voice)
(612) 626-2079 (fax)
msnyder@umn.edu (e-mail)

Appendix C

The Functional Approach to Volunteers' Motivations

Gil Clary
College of St. Catherine

and

Mark Snyder
University of Minnesota

Assumptions

1. People are purposeful, planful, goal-directed -- Volunteers engage in volunteer work in order to satisfy important personal goals
2. Different people may do similar things for different reasons – Volunteers performing the same volunteer activity for the same organization may have different reasons for volunteering
3. Any one individual may be motivated by more than one need or goal – An individual volunteer may be attempting to satisfy two or more motives through one activity at your organization
4. Outcomes depend on the matching of needs and goals to the opportunities afforded by the environment – Successful volunteer recruitment, satisfaction, and retention is tied to the ability of the volunteer experience to fulfil the volunteer's important motives

The Motivations for Volunteering

<u>Values function</u>	the person is volunteering in order to express or act on important values, such as humanitarianism and helping the less fortunate
<u>Understanding function</u>	the volunteer is seeking to learn more about the world and/or exercise skills that are often unused
<u>Enhancement function</u>	the individual is seeking to grow and develop psychologically through involvement in volunteering
<u>Career function</u>	the volunteer has the goal of gaining career-related experience through volunteering
<u>Social function</u>	volunteering allows the person to strengthen one's social relationships
<u>Protective function</u>	the individual uses volunteering to reduce negative feelings, such as guilt, or to address personal problems

Your organization is involved in a project related to volunteer's reasons and experiences with volunteering. On the following pages are two sets of items that concern your experiences as a volunteer with this organization. The first set, **Reasons for Volunteering**, presents 30 reasons that people volunteer and asks that you indicate how important each reason is for you for your volunteering at this organization. The second set, **Volunteering Outcomes**, presents 18 outcomes that can result from volunteering and asks that you indicate whether you have experienced each outcome. You do not need to put your name on the questionnaire.

Using the 7-point scale below, please indicate how important or accurate each of the following possible reasons for volunteering is for you in doing volunteer work at this organization. Record your answer in the space next to each item.

- | | not at all important/
accurate for you | 1 | 2 | 3 | 4 | 5 | 6 | 7 | extremely important/
accurate for you |
|---------------|--|---|---|---|---|---|---|---|--|
| Rating | | | | | | | | | |
| 1. | Volunteering can help me get my foot in the door at a place where I'd like to work. | | | | | | | | |
| 2. | My friends volunteer. | | | | | | | | |
| 3. | I am concerned about those less fortunate than myself. | | | | | | | | |
| 4. | People I'm close to want me to volunteer. | | | | | | | | |
| 5. | Volunteering makes me feel important. | | | | | | | | |
| 6. | People I know share an interest in community service. | | | | | | | | |
| 7. | No matter how bad I've been feeling, volunteering helps me to forget about it. | | | | | | | | |
| 8. | I am genuinely concerned about the particular group I am serving. | | | | | | | | |
| 9. | By volunteering, I feel less lonely. | | | | | | | | |
| 10. | I can make new contacts that might help my business career. | | | | | | | | |
| 11. | Doing volunteer work relieves me of some of the guilt over being more fortunate than others. | | | | | | | | |
| 12. | I can learn more about the cause for which I am working. | | | | | | | | |
| 13. | Volunteering increases my self-esteem. | | | | | | | | |
| 14. | Volunteering allows me to gain a new perspective on things. | | | | | | | | |
| 15. | Volunteering allows me to explore different career options. | | | | | | | | |
| 16. | I feel compassion toward people in need. | | | | | | | | |
| 17. | Others with whom I am close place a high value on community service. | | | | | | | | |
| 18. | Volunteering lets me learn through direct "hands on" experience. | | | | | | | | |

- 19. I feel it is important to help others.
- 20. Volunteering helps me work through my own personal problems.
- 21. Volunteering will help me succeed in my chosen profession.
- 22. I can do something for a cause that is important to me.
- 23. Volunteering is an important activity to the people I know best.
- 24. Volunteering is a good escape from my own troubles.
- 25. I can learn how to deal with a variety of people.
- 26. Volunteering makes me feel needed.
- 27. Volunteering makes me feel better about myself.
- 28. Volunteering experience will look good on my resume.
- 29. Volunteering is a way to make new friends.
- 30. I can explore my own strengths.

Volunteering Outcomes

Using the 7-point scale below, please indicate the amount of agreement or disagreement you personally feel with each statement. Please be as accurate and honest as possible, so we can better understand this organization.

<u>Rating</u>	Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree
— 31.	In volunteering with this organization, I made new contacts that might help my business or career.								
— 32.	People I know best know that I am volunteering at this organization.								
— 33.	People I am genuinely concerned about are being helped through my volunteer work at this organization.								
— 34.	From volunteering at this organization, I feel better about myself.								
— 35.	Volunteering at this organization allows me the opportunity to escape some of my own troubles.								
— 36.	I have learned how to deal with a greater variety of people through volunteering at this organization.								
— 37.	As a volunteer in this organization, I have been able to explore possible career options.								
— 38.	My friends found out that I am volunteering at this organization.								
— 39.	Through volunteering here, I am doing something for a cause that I believe in.								
— 40.	My self-esteem is enhanced by performing volunteer work in this organization.								

- 41. By volunteering at this organization, I have been able to work through some of my own personal problems.
- 42. I have been able to learn more about the cause for which I am working by volunteering with this organization.
- 43. I am enjoying my volunteer experience.
- 44. My volunteer experience has been personally fulfilling.
- 45. This experience of volunteering with this organization has been a worthwhile one.
- 46. I have been able to make an important contribution by volunteering at this organization.
- 47. I have accomplished a great deal of “good” through my volunteer work at this organization.

- 48. One year from now, will you be (please circle your best guess as of today):
 - A. volunteering at this organization.
 - B. volunteering at another organization
 - C. not volunteering at all.

Volunteer # _____

VFI Career Item
Response 1 10 15 21 28

_____ + _____ + _____ + _____ + _____ = _____
(SUM)

[illegible]

VFI Values	Item	3	8	16	19	22	
	Response	<u> </u>	+ <u> </u>	+ <u> </u>	+ <u> </u>	+ <u> </u>	= <u> </u> (SUM)

VFI Understd Item Response 12 14 18 25 30
_____ + _____ + _____ + _____ + _____ = _____
(SUM)

VFI Enhance	Item	5	13	26	27	29	
	Response	<u> </u>	+ <u> </u>	+ <u> </u>	+ <u> </u>	+ <u> </u>	= <u> </u> (SUM)

VFI Protect	Item	7	9	11	20	24	
	Response	<u> </u>	+ <u> </u>	+ <u> </u>	+ <u> </u>	+ <u> </u>	= <u> </u> (SUM)

Outcomes Career (Add items 31 and 37) _____ + _____ =

Outcomes Social (Add items 32 and 38) + =

Outcomes Values (Add items 33 and 39) _____ + _____ = _____

Outcomes Enhance (Add items 34 and 40) _____ + _____ =

Outcomes Protect (Add items 35 and 41) ____ + ____ =

Outcomes Understd (Add items 36 and 42) _____ + _____ = _____

Satisfaction Items 43 44 45 46 47
 Response — + — + — + — + — = —

Long-term Intentions (item 48) _____

Volunteering Outcomes

C = Career

Sc = Social

V = Values

E = Enhancement

P = Protective

U = Understanding

St = Satisfaction

Appendix D

Summary of Primary Research Evidence

Citation	Question	Design/ Tools/ Sample Size/ Evidence Level/Quality	Usefulness Results Key Findings	Recommendations/ Implications	Theoretical Foundation	Outcome Definition
Afari-Asiedu, S., Asante, K. P., Senah, K., Abdulai, M. A., Afranie, S., Mahama, E., Anane, E. A., Abukari, M., Darko, M. L., Febir, L. G., & Owusu-Agyei, S. (2018). Volunteering for health services in the middle part of Ghana: In whose interest? <i>International Journal of Health Policy and Management</i> , 7(9), 836–846. https://doi.org/10.15171/ijhpm.2018.38	To find what motivates community-based volunteers.	Design: Sequential mixed method; cross-sectional survey. Tools: a crossed sectional survey. Qualitative interviews: in-depth interviews and focus group discussion. Sample Size: 205 community-based volunteers. Evidence/Grade: Level I -A	Personal interest and community leader's selection of volunteers=key reasons. Motivations (t-shirts, bags, food during trainings, community recognition, social prestige.	Motivators: Personal interests. Monetary and non-monetary incentives. Recognition	The Social Exchange Theory.	Motivation and retention were influenced by personal interests in form of recognition by the community the provision of non-monetary and monetary incentives,

Albuquerque, S., Eriksson, A., & Alvesson, H. M. (2018). The rite of passage of becoming a humanitarian health worker: Experiences of retention in Sweden. <i>Global Health Action</i> , 11(1), 1. https://doi.org/10.1080/16549716.2017.1417522	To find what motivates and supports experienced humanitarian health workers to remain engaged.	Design: Semi-structured interviews. Research Tools Used: methodology of content analysis Sample Size: 10 HVs in 3 missions Data Analysis: Social dimensions of transformation Evidence/Grade: Level II-B	Social supports are important to facilitate rites of passage during humanitarian missions.	The experience and assistance during deployment and after having a great impact on the long-term commitment of a volunteer. Strengthen strategies to facilitate long-term commitment.	Genep's Theory "Rites of Passage"	Personal goals and the principle of assisting others during and after deployment is significant.
Chatio, S., & Akweongo, P. (2017). Retention and sustainability of community-based health volunteers' activities: A qualitative study in rural Northern Ghana. <i>PloS One</i> , 12(3), e0174002. https://doi.org/10.1371/journal.pone.0174002	Explore factors affecting retention and sustainability of CBHV activities.	Design: a qualitative study Tools: in-depth interviews, NVivo 10 software Sample Size: 32 Evidence/Grade: Level II-B	Desire to help, prestige, recognition motivated them to work as healthy volunteers. Lack of incentives and supplies affected work.	Community support, incentives, logistical supplies, awards are a mechanism to retain and sustain CBHV	Grounded Theory	Means of transport and non-monetary incentives help retain community-based volunteers and sustain. Social Support

Haski, L. D., Meijjs, L. C. P. M., Lockstone, B. L., Holmes, K., & Oppenheimer, M. (2018). Measuring volunteerability and the capacity to volunteer among non-volunteers: Implications for social policy. <i>Social Policy & Administration</i> , 52(5), 1139–1167. https://doi.org/10.1111/spol.12342	Willingness, capability, and availability of volunteers are affected by social support.	Design: Mixed method Tools Used: questionnaire Sample Size: 12 focus groups with a total of 1,700 responses Evidence/Grade: Level I-B	Understanding the willingness, capability, and availability to volunteer	The government should support state and national volunteers and allow volunteers to volunteer episodically, online, and through the workplace.	None	Opportunity for social policy to allow for volunteering.
Kim, E. J., Fox, S., Moretti, M. E., Turner, M., Girard, T. D., & Chan, S. Y. (2019). Motivations and barriers associated with physician volunteerism for an international telemedicine organization. <i>Frontiers in Public Health</i> , 7, 224. https://doi.org/10.3389/fpubh.2019.00224	To identify motivations and barriers that contribute to physician volunteerism in telemedicine.	Design: Descriptive statistics, qualitative approach. Tools: surveys; VFI framework Sample Size: 69 active and 25 inactive volunteers with a 74% response rate. Evidence/Grade: Level II-B	A motivator is the ability to connect with the patient.	Predictors of physician volunteerism are age and global health experience.	None	Develop effective recruitment and retention strategies.
Mays, D. C., O'Neil, E. J., Jr, Mworoz, E. A., Lough, B. J., Tabb, Z. J., Whitlock, A. E., Mutimba, E. M., & Talib, Z. M. (2017). Supporting and	To evaluate specific factors associated	Design: Mixed method with a survey and semi-	Desire for support such as transportation, supplies, and	Building stronger partnerships and providing	None	10-year longevity was positively

retaining village health teams: An assessment of a community health worker program in two Ugandan districts. <i>International Journal for Equity in Health</i> , 16(1), 129. https://doi.org/10.1186/s12939-017-0619-6	with long-term retention of VHT.	structured interviews Tools/ Sample Size: 134 VHT Evidence/Grade Level I-A	describe a lack of respect and support from communities and HVs.	regular supplies and transportation.		associated with stronger partnerships with local health center staff and ease in-home visits. Logistics and social support
McGeehan, L., Takehara, M. A., & Daroszewski, E. (2017). Physicians' perceptions of volunteer service at safety-net clinics. <i>The Permanente Journal</i> , 21, 16-003. https://doi.org/10.7812/TPP/16-003	To investigate the perceptions, motivations, functions, and barriers associated with physician volunteering.	Design: Mixed method Tools: surveys and interviews, Functions of volunteering from Clary et al Sample Size: 31 physicians Evidence/Grade Level II-B	Barriers were time, organizational, and supply issues. Most were motivated by humanitarian or prosocial desires	Appeal to the volunteer's sense of values, faith, and qualities of volunteering.	None	Appealing to values and faith and burnout prevention qualities of volunteering are key to recruitment and retention.
Meyer, M. A., Peek, L., Unnithan, N. P., Coşkun, R., Tobin-Gurley, J., & Hoffer, K. H. (2016). Planning for diversity: Evaluation of a volunteer disaster response program. <i>Journal of Cultural Diversity</i> , 23(3), 106–113.	Reliance on word of mouth recruiting remains commonplace; however,	Design: semi-structured phone interviews Tools Used: 21 open/closed ended questions; 2	National sometimes works in isolation of local volunteers.	Planning for diversity requires clear communication throughout the organization especially between	None	Inform volunteers of lack of diversity and seek non-traditional ways to recruit as

	adding diversity recruitment strategies and goals may increase recruitment.	cycle coding method Sample Size: 27 individuals Data Analysis: Review of responses Evidence/ Grade Level II-B		leadership at all levels.		well as involve strategies that improve communication with leadership.
Mlotshwa, L., Harris, B., Schneider, H., & Moshabela, M. (2015). Exploring the perceptions and experiences of community health workers using role identity theory. <i>Global Health Action</i> , 8, 28045. https://doi.org/10.3402/gha.v8.28045	To explore the perceptions, experiences, and identities of CHWs as they adopt a CHW role in rural South Africa using a 'role identity theory'	Design: semi-structured interviews Tools: Interviews Sample Size: 18 Evidence/ Grade Level II-B	A need exists for instrumental/material support for community acceptance	Allow the CHW to teach, promote health, become health systems representative supported with resources	Role Identify Theory	Understanding role identities and how to support them for retention strategies.
Moghaddam, H. R., Allahverdipour, H., & Matlabi, H. (2018). Successful recruitment and retention strategies for women health volunteers: viewpoints of the volunteers' supervisors and relevant	To find successful strategies to overcome barriers to	Design: Delphi technique Tools: questionnaires	Improve group work, implementing motivation tactics, allocating	Utilize incentives and logistical supplies such as prizes and	None	Community mobilization, incentive, and logistical supplies are

researchers. <i>Journal of Multidisciplinary Healthcare</i> , 11, 621–634. https://doi.org/10.2147/JMDH.S180544	recruitment and retention of volunteers.	Sample Size: Unknown Evidence/ Grade Level: II-C	resources, using social networks, and improving collaboration are some strategies for retention.	transportation for volunteers to retain CHWs.		mechanisms for retention.
Ngilangwa, D. P., & Mgomella, G. S. (2018). Factors associated with retention of community health workers in maternal, newborn, and child health programme in Simiyu Region, Tanzania. <i>African Journal of Primary Health Care & Family Medicine</i> , 10(1), e1–e8. https://doi.org/10.4102/phcfm.v10i1.1506	To understand factors associated with CHWs recruitment and retention.	Design: Cross-sectional study Tools: semi-structured questionnaires Sample Size: 341 CHW Evidence/Grade Level: II-A	Motivation factors were aspiration to serve, desire to become a qualified medical practitioner.	It is important to understand the motives for volunteering.	None	Retention of CHWs includes financial and non-financial incentives.
Ngugi, A. K., Nyaga, L. W., Lakhani, A., Agoi, F., Hanselman, M., Lugogo, G., & Mehta, K. M. (2018). Prevalence, incidence, and predictors of volunteer community health worker attrition in Kwale County, Kenya. <i>British Medical Journal Global Health</i> , 3(4), e000750. https://doi.org/10.1136/bmjgh-2018-000750	To measure CHW attrition and its predictors in a rural area.	Design: case-control study and focus group discussions Tools: Poisson model Sample Size: 1005 Evidence/Grade Level: II-B	The incidence of attrition was 46.8/1000 person-years. Lack of interest in the peer organization was associated with attrition. A heavy caseload was associated with attrition.	Ongoing training and feedback and peer support are important in retention. Expectations regarding the roles and benefits of CHWs are to be communicated clearly.	CHW attrition conceptual framework.	High prevalence and incidence of CHWs attrition.
Nothwehr, F., & Rohlman, D. (2019). Employer-supported volunteerism in	To understand	Design: Descriptive	Volunteerism has been linked to	Tailor to the interest of	None	Volunteerism may lead to

rural worksites. <i>Workplace Health & Safety</i> , 67(10), 512–519. https://doi.org/10.1177/2165079919862295	what small, rural worksites are doing about volunteerism.	statistics, review, and summary of common themes. Tools: online survey Sample Size: 38 worksites Evidence/Grade Level II-B	improved quality of life, reduced morbidity, and higher self-rated activities.	employees and incorporate health promotion programs.		increased employee engagement, improved productivity and recruitment, and retention.
O'Donohue, W., Martin, A., & Torugsa, N. (Ann). (2015). Understanding individual responses to failure by the organisation to fulfill its obligations: examining the influence of psychological capital and psychological contract type. <i>Human Resource Management Journal</i> , 25(1), 131–147. https://doi.org/10.1111/1748-8583.12055	To test a novel theoretical model predicting likely worker response in an emergency services organization using volunteer workers.	Design: Interviews Tools Used: PCS Sample Size: 592 volunteers Data Analysis: Review of PC/PsyCap responses Evidence/Grade Level I-A	PC: socio-emotional commitment. PsyCap includes 4 positive attributes: hope, optimism, resilience, self-efficacy.	Socio-emotional commitment leads to fulfilling organizational obligations.	None	Data reinforces the importance of sustaining functional relationships between leaders and volunteers to enhance performance and productivity.
Omoto, A. M., & Packard, C. D. (2016). The power of connections: Psychological sense of community as a predictor of volunteerism. <i>Journal of Social Psychology</i> , 156(3), 272-290.	To support the validity and utility of PSOC for understanding	Design: Questionnaires in a group survey then follow up questionnaire	Focus on antecedents of volunteerism: PSOC is a predictor of volunteerism.	Encourage people to get involved as volunteers in social issues and causes.	Volunteer Process Model; 1 st study is based on the New	Social relationships and psychological connections are potential

	ng volunteeris m.	Tools: Questionnaires Sample Size/: 140 retirees Analysis: hierarchical regression analyses Evidence/Gra de Level II-B		Connections to other people are crucial in predicting volunteerism especially PSOC.	Ecological paradigm and the 2 nd study is based on the Connectedn ess to nature.	pathways to volunteerism
Ortega Carpio, M. L., Martinez-Cousinou, G., & Morales-Fernández, E. J. (2018). Transformative volunteerism: An inventory of NGDO volunteers' motivations. <i>Human Service Organizations: Management, Leadership & Governance</i> , 42(1), 33–52. https://doi.org/10.1080/23303131.2017.1363103	Designing specific volunteer managemen t programs for recruitment, task assignment, and training sustain motivation.	Design: Structured interviews Tools Used: closed-ended questionnaire Sample Size: 376 volunteers Data Analysis: Principal component analysis Evidence/ Grade: Level IA	Volunteerism favors our vision of the world and promotes proposals for action and social transformation.	Volunteer as an agent of change or transformative volunteerism.	None	Assignment of tasks motivates volunteers and encourages change through social transformatio n.
Salmani, I., Seyedin, H., Ardalan, A., & Farajkhoda, T. (2019). Conceptual model of managing health care volunteers in disasters: A mixed method study. <i>Bio Med Central Health Services</i>	Volunteer preparednes s plans that are integrated	Design: Mixed method Tools Used:	Prioritize retention and motivation through plans for addressing	Utilize the preparedness phase to prepare HVs and utilize the response	None	Management of volunteers regarding preparedness , response,

<p><i>Research</i>, 19(1), 241. https://doi.org/10.1186/s12913-019-4073-6</p>	<p>into the risk reduction programs of the health system prove to work better.</p>	<p>Delphi; semi-structured interviews Sample Size: 22 health professionals. Theoretical sampling Data Analysis: a framework analysis Evidence/Grade: Level I-A</p>	<p>physical and mental health follow up after a mission.</p>	<p>phase to assign them appropriately; finally, during the post-response phase follow up physical and mental health status.</p>		<p>and follow-up may impact retention.</p>
<p>Sarti, A. J., Sutherland, S., Landriault, A., DesRosier, K., Brien, S., & Cardinal, P. (2017). Exploring the components of physician volunteer engagement: A qualitative investigation of a national Canadian simulation-based training programme. <i>British Medical Journal Open</i>, 7(6), e014303. https://doi.org/10.1136/bmjopen-2016-014303</p>	<p>To present a conceptual framework for the exploration of volunteer engagement and influencing for physician volunteers.</p>	<p>Design: qualitative analysis; semi-structured interviews and construction of a conceptual framework Tools/ Sample Size: 30 Evidence/Grade Level II-B</p>	<p>Framework elements include synergism of emotional, cognitive, and reciprocal engagement.</p>	<p>Retention is associated with leadership and career paths, intrinsic, keeping current, academic currency, personal recognition, and CV</p>	<p>Fredericks et al., Theory of engagement</p>	<p>Provides a preliminary framework for physician volunteer engagement.</p>
<p>Smith, S. L., & Grove, C. J. (2017). Bittersweet and paradoxical. <i>Nonprofit Management & Leadership</i>, 27(3), 353–369. https://doi.org/10.1002/nml.21250</p>	<p>Positive management practices lead to more</p>	<p>Design: Semi-structured interview protocol</p>	<p>How managers practice shape satisfaction and fatigue among skilled long-term volunteers</p>	<p>Volunteer management practices affect satisfaction and retention. Perception of</p>	<p>Herzberg's (1968) two-factor theory</p>	<p>Volunteer management practices regarding forms, frequency,</p>

	satisfied volunteers	Tools Used: open-ended questions Sample Size: 16 Data Analysis: MANOVA, ANOVA Evidence/Grade II-B		supportive Worker-organization relationship.		the timing of communication, recognition, and support services affect satisfaction and retention.
Vareilles, G., Marchal, B., Kane, S., Petrič, T., Pictet, G., & Pommier, J. (2015). Understanding the motivation and performance of community health volunteers involved in the delivery of health programmes in Kampala, Uganda: A realist evaluation. <i>British Medical Journal Open</i> , 5(11), e008614. https://doi.org/10.1136/bmjopen-2015-008614	To understand how, why, and under what circumstances a Red Cross capacity intervention influencing the motivation and performance of volunteers.	Design: case study design and realist evaluation. Constant comparative method Tools: interviews Sample Size: 1 manager and 15 volunteers Evidence/Grade Level II-C	Recognition of work and responsiveness to community needs are Findings that inform management of CHW and all other volunteers	Cater to the motivational states and changing needs of the volunteers leads to better performance.	Realist evaluative theory-driven inquiry	Feelings of autonomy, competence, and connectedness come from supportive supervision
Wilson, J., & Son, J. (2018). The connection between neighboring and volunteering. <i>City & Community</i> , 17(3), 720–736. https://doi.org/10.1111/cico.12324	Higher neighboring relationships lead to	Design: Interviews Tools Used: MIDUS	Regarding volunteers, behaviors are more important than attitudes.	Social media can be used to enhance neighboring relationships to	Sociological Theory	The influence of social connections might be

	volunteerin g.	Sample Size: 3,487 respondents Data Analysis: Review of responses Evidence/Gra de: Level I-A		engage in volunteering.		more likely to volunteer if socially integrated.
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Legend: Community-based Health Worker (CBHW); Village health teams (VHT); Psychological contract (PC) and Psychological capital (PsyCap); Community health workers (CHW); Women Health Volunteers (WHV); Curriculum vitae (CV); Psychological sense of community (PSOC); Volunteer Functions Inventory (VFI).

Appendix E

Summary of Themes

Themes	<p>Afari-Asiedu, S., Asante, K. P., Senah, K., Abdulai, M. A., Afranie, S., Mahama, E., Anane, E. A., Abukari, M., Darko, M. L., Febir, L. G., & Owusu-Agyei, S. (2018). Volunteer ing for health services in the middle part of Ghana: In</p>	<p>Albuquerque, S., Eriksso n, A., & Alvesson, H. M. (2018). The rite of passag e of becomi ng a humani tarian health worker : Experi ences of retenti on in Swede n. <i>Global Health Action</i>, 11(1),</p>	<p>Chatio, S., & Akweongo, P. (2017). Retention and sustainability of community-based health volunteers' activities: A qualitative study in rural Northern Ghana. <i>PloS One</i>, 12(3), e0174002. https://doi.org/10.1371/journal.pone.0174002</p>	<p>Mlotshwa, L., Harris, B., Schneider, H., & Moshabela, M. (2015). Exploring the perceptions and experiences of community health workers using role identity theory. <i>Global Health Action</i>, 8, 28045. https://doi.org/10.3402/gha.v8.28045</p>	<p>Ngilangwa, D. P., & Mgomella, G. S. (2018). Factors associated with retention of community health workers in maternal, newborn, and child health programme in Simiyu Region, Tanzania. <i>African Journal of Primary Health Care & Family Medicine</i>, 10(1), e1–e8. https://doi.org/10.4102/phcfm.v10i1.1506</p>	<p>Ngugi, A. K., Nyaga, L. W., Lakhani, A., Agoi, F., Hanselman, M., Lugogo, G., & Mehta, K. M. (2018). Prevalence, incidence, and predictors of volunteer community health worker attrition in Kwale County, Kenya. <i>British Medical Journal Global Health</i>, 3(4), e000750. https://doi.org/10.1136/bmjgh-2018-000750</p>	<p>Salmani, I., Seyedin, H., Ardalan, A., & Farajkhoda, T. (2019). Conceptual model of managing health care volunteers in disasters: A mixed method study. <i>Bio Med Central Health Services Research</i>, 19(1), 241. https://doi.org/10.1186/s12913-019-4073-6</p>
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	whose interest? <i>International journal of health policy and management</i> , 7(9), 836–846. https://doi.org/10.15171/ijhpm.2018.38	1. https://doi.org/10.1080/16549716.2017.1417522					
Mentoring	Recognition by Community	Support system	Recognition	Community acceptance	Supportive supervision	Supportive peer Supervision & feedback	Supervision
Education and Training	Receive and provide training	Supervision and mentoring	Learning and awareness	Role identity learn and teach	Refresher training and further training	Ongoing training and acquisition of knowledge	Preparedness
Social Support	Social prestige	Rite of passage	Sense of responsibility Prestige	Become representatives	Importance to the community	Clear expectations Sense of accomplishment	Social fun and respect at all stages

Legend: Non-government Organizations (NGO)

Appendix F

Strengths, Weakness, Opportunities, and Threats Analysis

Internal Factors	External Factors
<p style="text-align: center;">Strengths</p> <ul style="list-style-type: none"> ○ A strong mission, vision, core values, and pillars with a guiding philosophy. ○ History of volunteerism in existence since 1881. ○ Reputation and respect internationally and known for responding to disasters globally. ○ Technology, resources, and leadership support for training. 	<p style="text-align: center;">Opportunities</p> <ul style="list-style-type: none"> ○ Increase collaboration with local healthcare organizations during disasters. ○ Improve coordination with colleges for support before disaster relief efforts.
<p style="text-align: center;">Weakness</p> <ul style="list-style-type: none"> ○ Reduced healthcare volunteer participation ○ Lack of established structured mentoring, education, and training. ○ Lack of a retention program. 	<p style="text-align: center;">Threats</p> <ul style="list-style-type: none"> ○ Exhausting volunteer resources caused by longstanding disaster relief missions. ○ Multiple disasters and humanitarian needs affecting the area locally.

Appendix G**EBP Project Schedule**

Action	Schedule	Responsibility
1. USAHS and IVO approve EBP Project	June 14-20, 2020	PM
2. Discuss EBP implementation and projected budget	June 21-27, 2020 (W1)	PM, RDHSL
3. Baseline data analysis to stakeholders	June 21-27, 2020 (W1)	PM, RDHSL
4. Introduction of planned EBP project	June 21-27, 2020 (W1)	PM, RDHSL
5. Created and administered VFI pre-implementation survey	June 28-July 4, 2020 (W2)	PM
6. Educated mentors	June 28-July 4, 2020 (W2)	PM, RDHSL
7. Implementation of Healthcare Volunteer Retention Program	July 4-September 12, 2020 (W3-12)	PM, RDHSL
8. VFI pre-implementation survey analysis to stakeholders	August 9-15, 2020 (W8)	PM
9. Administered VFI post-implementation survey	September 6-12, 2020 (W12)	PM
10. VFI post-implementation survey analysis to stakeholders	September 13-19, 2020	PM
11. Outcome data analysis with Statistician	September 13-19, 2020	PM, Statistician
12. EBP project evaluation presented results to stakeholders	September 20-26, 2020	PM

Legend: University of St. Augustine Health Sciences (USAHS); Interdisciplinary Volunteer Organization (IVO); Program Manager (PM);

Evidence-based Practice (EBP); Week (W); Regional Disaster Health Services Lead (RDHSL); Volunteer Functions Inventory (VFI);

Appendix H

Measures for Healthcare Volunteer Retention Program (HVRP)

Measure	Actions	Benchmark	Goal	Data Type
Outcome Measure	Retention Rate per 100 - Healthcare Worker Retention Rate Percentage. The numerator is the number of healthcare worker volunteers who stayed for a whole time divided by the number of healthcare worker volunteers at the start of a period and multiply by 100.	5%	≥50%	Continuous data
Outcome Measure	Percent of Healthcare Volunteer Intent to stay.	5%	≥50%	Continuous data x2 paired
Outcome Measure	Percent of Healthcare Volunteer satisfaction.	5%	≥50%	Continuous data x2 paired
Process Measure	Percent of Mentor education and training. The numerator is the actual number of mentors who completed HVRP training and the denominator is the total number of Mentors who have implemented the HVRP	50%	≥75%	Continuous data x ²
Balance Measure	Percent of volunteers satisfied with the HVRP	5%	≥50%	Continuous data
Financial Measure	Cost of Training. The number of volunteers who responded to the surveys multiplied by a \$5 incentive.			
Sustainability Measure	Percent of Volunteers enrolled in the HVRP. The numerator is the total mentees enrolled and the denominator is the total number of volunteers.	75%	≥75%	Continuous data x ²